

completion of the operation. This practice is the more to be recommended from our ignorance of the conditions under which air gains entrance by dilated subcutaneous veins. In wounds of the external jugular, the central end should always be tied, as it should be prior to operations likely to lead to its being opened. Under other circumstances, the ligature of large veins should be avoided as much as possible, especially in hospitals, where the danger from thrombosis and pyæmia is increased. The internal coat of a large vein is not divided by the ligature, as in the case of an artery; and the inner walls approximated by the ligature may unite before the separation of the latter—the vessel remaining pervious, though somewhat narrower, up to the very seat of the ligature. When inflammation follows a wound or a ligature, more or less extensive thrombosis may succeed, which may lead to detachment of coagula or pyæmia. When this is not the case, the vein gradually becomes pervious again; and so great is the regenerative capacity of veins, that, even when large portions have been removed, these may be reproduced, effecting a junction between the separated ends of the still pervious vessel.

Ligature of the Artery.—It is obvious, *à priori*, that compression or ligature of the corresponding arterial trunk, by preventing the access of blood, must arrest hemorrhage from a large vein; but it does not appear that any one has yet practised the ligature for such a purpose. One reason of this seems to be derived from the fact that when compression of an arterial trunk, as the carotid, subclavian, or femoral, has been made, through the soft parts, at some point between the heart and the bleeding wound, the bleeding from the jugular, axillary, or femoral vein has not immediately ceased. This is partly because the peripheric veins still continue to pour their blood into the injured vein, and partly because an effectual compression of the carotid or femoral artery is not possible without accompanying compression of the jugular or femoral vein. Compression of the arterial trunk, therefore, not having been attended with the same immediate effect as in arterial hemorrhage, it has been believed that no good result was to be expected from the ligature. Again, it has continued, until the most recent times, a cherished opinion among most surgeons, that the simultaneous tying of a large venous and arterial trunk must give rise to gangrene—a fear which experience has shown to be unjustifiable. In fact, when both artery and vein are tied, not only does no gangrene follow, but there is less disturbance of the capillary circulation than when only one of these vessels is submitted to the ligature. In two cases related by the author in which the carotid and common jugular were both tied, no disturbance whatever of the cerebral circulation took place, and neither patient exhibited any of the symptoms which have been met with when ligature of the carotid alone has been practised. During the establishment of the collateral circulation an equilibrium between the arteries and veins has been maintained. In this ligature of the artery, then, we have a safe means of treating venous hemorrhages which may otherwise prove fatal, and the author relates a case in which he made application of it. During the removal of a large sarcomatous tumour from the thigh, the much-enlarged and brittle femoral vein was opened. The hemorrhage was excessive, repeatedly resisting every attempt to arrest it, and the patient was well-nigh lost. The femoral artery, already exposed during the operation, was tied, and the bleeding at once ceased. The ligatures which had been passed around the vein were removed, and the wound dressed. The patient did well. This, as far as the author is aware, is the only case in which an arterial trunk has been intentionally tied for the arrest of a dangerous venous hemorrhage. He refers, however, to cases quoted by Dr. Crisp, in which bleeding from wounds of the vein made during the operation for popliteal aneurism ceased after the application of the ligature to the artery. The author recommends that as soon as compression proves without avail in hemorrhage from large venous trunks that the artery should be at once tied—the simultaneous tying of the injured vein being unnecessary and unadvisable from the danger of thrombosis it gives rise to.—*B. and F. Med.-Chir. Rev.*, Jan., 1861, from *Archiv für Klinische Chirurgie*.

32. *Ovariectomy in London Hospitals.*—The following table, taken from a late number of the *British Medical Journal* (Dec. 1860), embraces, it is said,

all the operations performed during the last three years in the London hospitals, except those in the practice of Mr. Baker Brown at the "London Home."

The operations are numbered in the order of their performance.

No.	Hospital.	Operator.	Date of operation.	Result.
1	Samaritan	Mr. S. Wells	Feb. 1858	Recovered
2	Metropolitan Free	Mr. Hutchinson	Aug. "	Do.
3	Ditto	Ditto	Aug. "	Died
4	Ditto	Ditto	Sept. "	Do.
5	Samaritan	Mr. S. Wells	Sept. "	Recovered
6	Metropolitan Free	Mr. B. Childs	Nov. "	Died
7	Samaritan	Mr. S. Wells	Nov. "	Recovered
8	University College	Mr. Erichsen	Nov. "	Died
9	Samaritan	Mr. S. Wells	Jan. 1859	Do.
10	Guy's	Mr. C. Forster	Feb. "	Do.
11	Metropolitan Free	Mr. B. Childs	Feb. "	Do.
12	Samaritan	Mr. S. Wells	May "	Recovered
13	Ditto	Ditto	June "	Died
14	Ditto	Ditto	June "	Recovered
15	Ditto	Ditto	July "	Do.
16	Ditto	Ditto	Oct. "	Do.
17	Westminster	Mr. Holt	Oct. "	Died
18	Samaritan	Mr. S. Wells	Dec. "	Do.
19	Ditto	Ditto	Jan. 1860	Recovered
20	London	Mr. Curling	Feb. "	Died
21	Samaritan	Mr. S. Wells	Feb. "	Do.
22	Middlesex	Mr. Nunn	Oct. "	Do.

The result, it will be perceived, is 13 deaths and 9 recoveries. Two of the latter, however, after recovering from the operation, died some months afterwards of cancer.

33. *Ovariectomy in Canada*.—Dr. REGINALD HENWOOD, of Brantford, C. W., records a case of ovarian tumour in an unmarried woman, 38 years of age, in whom he removed the tumour, through an incision extending from two inches above the umbilicus to within an inch of the pubis. No anæsthesia was used. The tumour proved to be the right ovary, and weighed $7\frac{1}{2}$ pounds, twenty-four hours after removal, when it must have lost a considerable portion of its weight. The wound healed by the first intention. In seven weeks the patient was able to go home.—*British Am. Journ.*, Dec. 1860.

34. *Extirpation of the entire Parotid*.—M. MARZOLO relates (*Gazetta Medica Italiana*) a case of a woman 50 years of age, in whom he extirpated, he asserts, the entire parotid, preserving the facial nerve and the external carotid artery. In six weeks the cure was complete, and eleven years afterwards she remained in perfect health, presenting no indication of a return of the disease.—*Gaz. Méd. de Paris*, Jan. 5, 1861.

35. *Removal of Inferior Maxilla for Osteo-Sarcoma*.—Dr. J. R. DICKSON, Prof. Surg. in Univ. of Queen's Coll., Kingston, C. W., reports (*British Am. Journ.*, Feb. 1861), a case of this in a man 60 years of age, having a rapidly increasing malignant osteo-sarcomatous tumour extending along the entire left half of the inferior maxilla. The operation was performed on the 18th of June, 1855, the patient being partially under the influence of chloroform. The case went on favourably, and on the 22d of July the patient was discharged, apparently cured. On the 13th of the following Dec. the patient returned, with a reappearance of the disease in the cicatrix, and on the 16th of March, 1856, death terminated his sufferings, nearly nine months after the operation.